2021
SUMMARY OF BENEFITS

SOLIS Health Plans **SPF 010 (HMO D-SNP)**

January 1, 2021 - December 31, 2021

H0982, Plan 010 - Hillsborough County

Solis Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This summary of benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" (EOC) online at www.solishealthplans.com or call us and request a copy.

What does Solis Health Plans (HMO D-SNP) Cover?

Like all Medicare health plans, we cover everything than Original Medicare covers—**and more!**

- ✓ Our members receive more benefits that are covered by Original Medicare. Some of these supplemental benefits are outlined in this Summary of Benefits.
- ✓ We cover Part D drugs. You can see Solis's Comprehensive Prescription Drug List (formulary) on our website at www.solishealthplans.com or call toll-free (844) 447-6547 (TTY 711).
- ✓ Solis has a network of hospitals, doctors, specialists, pharmacies, and other providers ready to serve all of your healthcare needs. You can access the Provider Directory on our website at www.solishealthplans.com or call toll-free (844) 447-6547 (TTY 711). Services are available when using an in-network provider. Out of network provider services are not covered except in emergency situations.

Medicare Plan Finder on www.medicare.gov allows you to compare our plan with other plans for their Summary of Benefits.

If you are already a member of Solis Health Plans, call toll-free (844) 447-6547 (TTY 711). Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call weekends, holidays and after hours.

To join **Solis Health Plan (HMO D-SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: **Hillsborough.**

You must also qualify for one of the following Medicaid programs:

- Qualified Medicare Beneficiary Plus (QMB+): You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayments amounts.

- Qualified Medicare Beneficiary (QMB): You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance and copayments amounts only.

- Qualified Disabled and Working Individual (QDWI): Medicaid pays your Part A premium only.

- Qualifying Individual (QI): Medicaid pays your part B premium only.

- Specified Low-Income Medicare Beneficiary (SLMB+): You get full Medicaid benefits, and Medicaid pays your Part B premium.

- Specified Low-Income Medicare Beneficiary (SLMB): Medicaid pays your Part B premium only.

- Full Benefits Dual Eligible (FBDE): Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This document is available in other formats such as braille, large print or audio.

For more information, please call us at (844) 44-SOLIS(76547) / (TTY : 711), or visit us at https://solishealthplans.com. 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30.

SPF 010 (HMO D-SNP) H0982-010

Monthly Plan Premium

- $30.80
- You must continue to pay your Part B premium.

Deductible

- No deductible

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)

- You pay no more than $2,500 annually
- Includes copays and other costs for medical services for the year

BENEFITS

Inpatient Hospital[A,R]

- $0 Copayment

Outpatient Hospital[A,R]

- $0 Copayment

Doctor Visits

• Primary Care:	$0 Copayment
• Specialists:[A,R]	$0 Copayment

Preventive Care (e.g., flu vaccine, diabetic screenings)

- $0 Copayment
  - Abdominal aortic aneurysm screening[R]
  - Annual "wellness" visit
  - Bone mass measurement[R]
  - Breast cancer screening (mammogram)[R]
  - Cardiovascular disease risk reduction visit
  - Cardiovascular disease testing[R]
  - Cervical and vaginal cancer screening[R]
  - Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)[A.R]
  - Depression screening
  - Diabetes screenings
  - HIV screening
  - Immunizations[R]
  - Lung cancer screenings[R]
  - Medical nutrition therapy[R]
  - Medicare Diabetes prevention program[R]
  - Obesity screenings and therapy[R]
  - Prostate cancer screenings (PSA)
  - Screening and counseling to reduce alcohol misuse
  - Sexually transmitted infections screenings and counseling[R]
  - Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)[R]
  - "Welcome to Medicare" preventive visit (one-time)

A - Authorization may be required **R** - Referral may be required

Emergency Care / Post-Stabilization Care

- $0 Copayment
- International Emergencies - $50,000 annual benefit max

Urgently Needed Services

- $0 Copayment

Diagnostic Services/Labs/Imaging[A,R]

Medicare-covered Diagnostic Procedures / Tests:
- $0 Copayment

Medicare-covered Lab Services:
- $0 Copayment

Medicare-covered X-Ray Services:
- $0 Copayment

Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.):
- $0 Copayment

Medicare-covered Therapeutic Radiological Services:
- $0 Copayment

Hearing Services (Routine Hearing Exam and Hearing Aid)[A,R]

- $0 Copayment
- $1,000 Hearing Aid allowance per ear ($2,000 total allowance)

Unlimited Routine Hearing Exams

Dental Services (Preventive)[R]

• Oral Exam	$0 Copayment – 2 exams every year
• Cleaning	$0 Copayment – 2 Cleanings every year
• Fluoride Treatment	$0 Copayment – 2 treatments every year
• Dental X-Rays	$0 Copayment – 2 X-Rays every year

A - Authorization may be required **R** - Referral may be required

Dental Services (Comprehensive)[A,R]	
• Diagnostic Services	$0 Copayment – 1 service every year
• Restorative Services	$0 Copayment – 6 services every year
• Endodontics	$0 Copayment – 1 service every year
• Periodontics	$0 Copayment – 2 service every year
• Extractions	$0 Copayment – 5 extractions every year
• Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services	$0 Copayment – 1 service every 2 years

Vision Services[A,R]	
• Eye exams:	$0 Copayment – 1 exam every year in addition to Medicare covered services.
• Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades:	$300 annual total allowance

Mental Health Services[A,R]	
• Inpatient hospital (Psychiatric)	$0 Copayment
• Outpatient group therapy/ individual therapy visit	$0 Copayment

Skilled Nursing Facility (SNF)[A,R]

- $0 Copayment

2 day prior network hospital admissions prerequisite

Rehabilitation Services (Occupational Therapy/Physical Therapy/Language Therapy)[A,R]

- $0 Copayment

Ambulance[A]

- $0 Copayment

A - Authorization may be required **R** - Referral may be required

Transportation[R]

- $0 Copayment
- Unlimited trips to plan approved health-related locations

Medicare Part B Drugs[A]

- $0 Copayment

Ambulatory Surgical Center[A,R]

- $0 Copayment

Fitness[R]

- Silver & Fit - Gym Membership $0 Copayment

Foot Care (Podiatry Services)[A,R]

- $0 Copayment

Unlimited Routine Care

Meals[A]

- $0 Copayment

The plan covers up to 14 meals for 7 days. Meals are covered after a hospital admission stay.

Medical Equipment/Supplies

- Diabetic Supplies[R] $0 Copayment
- Diabetic Therapeutic Shoes or Inserts[R] $0 Copayment

Diabetic Supplies and Services limited to those from specified manufacturers

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- Durable Medical Equipment (e.g., wheelchairs, oxygen)[A,R] $0 Copayment
- Prosthetic Devices[A,R] $0 Copayment

The plan has preferred vendors / manufacturers for Durable Medical Equipment (DME)

Over-the-Counter

- $0 Copayment

The plan covers up to $225 every 3 months for plan approved over-the-counter and health-related products.

A - Authorization may be required **R** - Referral may be required

Prescription Drugs

Deductible Stage	The plan has no deductible stage			
	Standard Retail Rx 30-day supply	Standard Retail Rx 90-day supply	Out-of-Network Retail Rx 30-day supply	Mail Order 90-Day Supply
Initial Coverage - You stay in this stage until your year-todate "total drug costs". (your payments plus any Part D plan's payments) total $4,130.				
Tier 1: Preferred Generic	You pay $0 copay	You pay $0 copay	You pay $0 copay	You pay $0 copay
Tier 2: Generic	You pay $0 copay	You pay $0 copay	You pay $0 copay	You pay $0 copay
Tier 3: Preferred Brand	You pay $0 copay	You pay $0 copay	You pay $0 copay	Mail order is not available for drugs in tier 3
Tier 4: Non-Preferred	You pay 25% coinsurance	You pay 25% coinsurance	You pay 25% coinsurance	Mail order is not available for drugs in tier 4
Tier 5: Specialty Tier	You pay 25% coinsurance	Rx 90-day supply is not available in Tier 5	You pay 25% coinsurance	Mail order is not available for drugs in tier 5
Tier 6: Supplemental Drugs	You pay $0 copay	You pay $0 copay	You pay $0 copay	You pay $0 copay
Coverage Gap - You stay in this stage until your year-todate "out-of-pocket costs" (your payments) reach a total of $6,550.				
Tier 1: Preferred Generic	You pay $0 copay	You pay $0 copay	You pay $0 copay	You pay $0 copay
Tier 2: Generic	You pay $0 copay	You pay $0 copay	You pay $0 copay	You pay $0 copay
For all other drugs, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand-name drugs.				

Prescription Drugs

	Standard Retail Rx 30-day supply	Standard Retail Rx 90-day supply	Out-of-Network Retail Rx 30-day supply	Mail Order 90-Day Supply
Catastrophic Coverage- During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2021).				
Tier 1: Preferred Generic	You pay either 5% of the cost of the drug or $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs. (whichever is the larger amount)
Tier 2: Generic				
Tier 3: Preferred Brand				
Tier 4: Non-Preferred				
Tier 5: Specialty Tier				
Tier 6: Supplemental Drugs	You pay $0 copay	You pay $0 copay	You pay $0 copay	You pay $0 copay

Individuals with "Extra Help" will pay a different copayment or coinsurance amount for Part D drugs. The amount you will pay depends on your qualified level. The table below demonstrates what you will pay if you qualify for "Extra Help" and how much you will pay in the different levels.

"Extra Help" Level	Your cost sharing amount for generic/preferred multi-source drugs is no more than	Your cost sharing amount for all other drugs is no more than
Level 1	$3.70	$9.20
Level 2	$1.30	$4.00
Level 3	$0	$0
Level 4	15% coinsurance	15% coinsurance

This information is not a complete description of benefits.
Call 1 (844) 447-6547 / (TTY : 711) 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31
8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30 for more information.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-447-6547 (TTY: 711).

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-844-447-6547, TTY 711.

Understanding the Benefits

- [ ] Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.solishealthplans.com or call 1-844-447-6547, TTY 711 to view a copy of the EOC.
- [ ] Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- [ ] Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- [ ] In addition to your monthly plan, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- [ ] Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- [ ] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- [ ] This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on a verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.